mR

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

Tijuan Townsend

(Enter above the full name of the plaintiff or plaintiffs in this action)

vs.

Chicago Police officer # 15112 Nicholas Cortesi
(Mayor) Rahmeal Emanuel
(Cheif of police) Gary Marcarthy
City of Chicago

(Enter above the full name of ALL defendants in this action. Do not use "et al.")

16-cv-2279
Judge Milton I. Shadur
Magistrate Judge Jeffrey T. Gilbert

Case No: PC2
(To be supplied by the Clerk of this Court)

CHECK ONE ONLY:

✓ **COMPLAINT UNDER THE CIVIL RIGHTS ACT, TITLE 42 SECTION 1983 U.S. Code** (state, county, or municipal defendants)

_____ **COMPLAINT UNDER THE CONSTITUTION ("BIVENS" ACTION), TITLE 28 SECTION 1331 U.S. Code** (federal defendants)

_____ **OTHER** (cite statute, if known)

BEFORE FILLING OUT THIS COMPLAINT, PLEASE REFER TO "INSTRUCTIONS FOR FILING." FOLLOW THESE INSTRUCTIONS CAREFULLY.

I. Plaintiff(s):

A. Name: TiJuan Townsend

B. List all aliases: Fred Townsend

C. Prisoner identification number: # 20140418312

D. Place of present confinement: Cook County Jail

E. Address: po Box 089002, Chicago IL. 60608

(If there is more than one plaintiff, then each plaintiff must list his or her name, aliases, I.D. number, place of confinement, and current address according to the above format on a separate sheet of paper.)

II. Defendant(s):

(In **A** below, place the full name of the first defendant in the first blank, his or her official position in the second blank, and his or her place of employment in the third blank. Space for two additional defendants is provided in **B** and **C**.)

A. Defendant: Nicholas, Cortesi

Title: Chicago police officer

Place of Employment: Chicago police station

B. Defendant: Rahmeal Emanueal

Title: The Mayor

Place of Employment: Chicago

C. Defendant: Gary Marcarthy

Title: Cheif of police

Place of Employment: Chicago police station

(If you have more than three defendants, then all additional defendants must be listed according to the above format on a separate sheet of paper.)

III. List ALL lawsuits you (and your co-plaintiffs, if any) have filed in any state or federal court in the United States:

A. Name of case and docket number: NONE

B. Approximate date of filing lawsuit: N/A

C. List all plaintiffs (if you had co-plaintiffs), including any aliases: N/A

N/A

D. List all defendants: N/A

N/A

E. Court in which the lawsuit was filed (if federal court, name the district; if state court, name the county): NONE

F. Name of judge to whom case was assigned: N/A

G. Basic claim made: N/A

H. Disposition of this case (for example: Was the case dismissed? Was it appealed? Is it still pending?): N/A

I. Approximate date of disposition: N/A

IF YOU HAVE FILED MORE THAN ONE LAWSUIT, THEN YOU MUST DESCRIBE THE ADDITIONAL LAWSUITS ON ANOTHER PIECE OF PAPER, USING THIS SAME FORMAT. REGARDLESS OF HOW MANY CASES YOU HAVE PREVIOUSLY FILED, YOU WILL NOT BE EXCUSED FROM FILLING OUT THIS SECTION COMPLETELY, AND FAILURE TO DO SO MAY RESULT IN DISMISSAL OF YOUR CASE. CO-PLAINTIFFS MUST ALSO LIST ALL CASES THEY HAVE FILED.

IV. Statement of Claim:

State here as briefly as possible the facts of your case. Describe how each defendant is involved, including names, dates, and places. **Do not give any legal arguments or cite any cases or statutes.** If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. (Use as much space as you need. Attach extra sheets if necessary.)

On April 17, 2014 I was Arrested by Chicago police officers (1) Cortesi #15112, McAuliffe #3636, Cobb #13966, Connoeey #13184, Ramalla #1775, Guerin #4634 musgraves #15154. These members Arrested me for a delivery of a Controlled subtanee. While inside the police station at homen and filmore, office Cortesi enter the interview that I was plaee in, and told me to plaee my hands on the the wall. I Complied and ask him what was I being Arrested for? he told me to "shut up. I state to him that he should "shut up- he then took his fist hitting me in the face and mouth, I was taken to saint Anthony hospital, where I was treated for A laceration to my lip, and a bruise mouth. there were picture tooken at the hospital, and the public defender offices. the Charges Against me are false, and this matter is being investigated by The

Independent Police Review Authority
The City of Chicago has employed Mayor Rahmeal Emanueal, Mayor Emanueal employed Cheif of police Gary Marcarthy, and marcarthy employed Chicago police officer Nicholas Cortesi that is how each defendant is involved.

officer Cortesi used escessive force in the Cource of his duty. this is A Esclessire force Clam.

7-28-14

1 of 2

To whom this May Concern:
This is a hand writen Complaint against several members of the Chicago police department. From the Homen and filmore station. here (ARE) is the names of the officers that I would like to be Investigatit."

1. COBB-13966
2. MCCANN-3636
3. CONNOLLY-13184
4. MUSGRAVES-15154
5. RAMAGLIA-1775
6. Guerin-4634
7. Cortesi-15112

ON April 17, 2014, I was Arrested by these members of the police department for A Delivery of Controlled, subtance, I was place inside a interview room at homen and filmore, when officer Cortesi" Came in the room, and told me to stand up" and place my hands on the Wall. "I complied" at the same time asking him what was I being arrested for? he then told me to (quote) "shut the fuck up." I stated to him that I was grown," and that he should shut the fuck up." He then took his fist hitting me in the face and mouth, Knocking me to the Floor, I was taken to saintanthony hospital, where thay treated me for a laceration and bruise mouth, there were pictures tooken at the hospital, and the public defender offices. After I return from the Hospital back to Homen and filmore police station. I was told that I would be

"OFFICIAL SEAL"
L. S. Pickens
Notary Public, State of Illinois
My Commission Expires April 12, 2016

1/30/2015

7-30-14

let go" only if I could either give them A Gun, or give them some Information on someone that posess them." other then that I would be charge with, a delivery and a aggravated battery to a police officer. officer Cortesi used escessive foree on me." And these charges against me (ARE) is false. I would like for this matter to be investigatid by Internal Affairs Divison and the Independent police Review Authority.

7/30/2014

FRED Townsend

"OFFICIAL SEAL"
L. S. Pickens
Notary Public, State of Illinois
My Commission Expires April 12, 2016

7-28-14

V. Relief:

State briefly exactly what you want the court to do for you. Make no legal arguments. Cite no cases or statutes.

I want Justice For what was done to me, and to be Compensate for the pain and suffering that I have been through. for the City of Chicago to pay my medical bills and reward me with three hundred thousand dollars

VI. The plaintiff demands that the case be tried by a jury. ☑ YES ☐ NO

CERTIFICATION

By signing this Complaint, I certify that the facts stated in this Complaint are true to the best of my knowledge, information and belief. I understand that if this certification is not correct, I may be subject to sanctions by the Court.

Signed this 3rd day of Feb., 2016

Tijuan Townsend
(Signature of plaintiff or plaintiffs)

Ti'Juan Townsend
(Print name)

20140418312
(I.D. Number)

P.O. Box 089002

Chicago Illinois 60608
(Address)

INDEPENDENT POLICE REVIEW AUTHORITY

1615 West Chicago Ave,
4th Floor Chicago,Il,60622
(312) 746-3609
Scott M. Ando, Chief Administrator

Reference: Log No. 1070793

FRED TOWNSEND

OCT 19 2015

Dear Fred Townsend,

The Independent Police Review Authority (IPRA) has completed the investigation into your complaint and forwarded its recommendation to the Chicago Police Department. The completed IPRA investigation and recommended findings will be subject to a Police Department review and potentially other review processes before the recommended finding becomes final. These review processes may take several months to complete.

You will be informed by letter of the final disposition of your case after the review processes have been finalized. In the meantime, IPRA wanted to thank you for bringing the matter to our attention and for your cooperation.

Very truly yours,

Scott M. Ando
Chief Administrator
Independent Police Review Authority

SAINT ANTHONY HOSPITAL

FACESHEET

PATIENT

MEDICAL RECORD #	VISIT #	ADMISSION DATE / TIME	LOCATION
2796347	200509539	04/17/2014 09:59	UNKNOWN_LOCATION-UNKNOWN_ROOM-UNKNOWN_BED

PATIENT TYPE	SERVICE	ADMITTED BY:
EMERGENCY	EMERGENCY	mhernan1

NAME AND ADDRESS	PREFERRED LANGUAGE FOR DISCUSSING HEALTH CARE	TELEPHONE	BIRTHDATE	AGE	SEX	MARITAL STATUS
TOWNSEND, TIJUAN 1225 S AUSTIN BOULEVARD CHICAGO, IL 60804 **Ethnicity** NON HISPANIC OR LATINO ETHNICITY	English	(773) 678-8972	09/14/1978	35Y	Male	Single

EMPLOYER NAME	EMPLOYER PHONE
CPD CUSTODY CPD CUSTODY CHICAGO, IL 60623	(111) 111-1111

NOK

EMERGENCY CONTACT NAME AND ADDRESS RELATION	NEXT OF KIN NAME AND ADDRESS RELATION
, ,	TOWNSEND, MERYLIN , (708)(708)863-3840 OTHER RELATIONSHIP

GUAR

GUARANTOR		GUARANTOR EMPLOYER
TOWNSEND, TIJUAN 1225 S AUSTIN BOULEVARD CHICAGO, IL 60804	TELEPHONE (773) 678-8972	CPD CUSTODY CPD CUSTODY CHICAGO, IL 60623

INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
TOWNSEND, TIJUAN SELF PAY 1111 NA NA, IL (0)0-0	, ,

DR.

ADMITTING PHYSICIAN	REFERRING PHYSICIAN
GRIMES, EPHRIAM 120535	GRIMES, EPHRIAM 120535
ATTENDING PHYSICIAN	**ER PHYSICIAN**
GRIMES, EPHRIAM 120535	,

VS

COMPLAINT	TREATMENT AUTHORIZATION
cpd custody battery pcp unknown	

SSSSS

SAINT ANTHONY HOSPITAL

Saint Anthony Hospital
2875 W. 19th Street
Chicago, IL 60623
773-484-1000

TOWNSEND, TIJUAN
MR#: 2796347
Visit ID: 200509539
Admit Date: 04/17/2014 09:59
Birth Date: 09/14/1978

1. CONSENT FOR DIAGNOSIS AND TREATMENT
I, for myself (or the patient named above), voluntarily authorize and consent to such diagnostic procedures, tests and treatments at Saint Anthony Hospital ("SAH"), which may be deemed necessary and advisable by my physician, his/her designee or any assistants or consultants for the diagnosis or treatment of my illness.

2. RESPONSIBILITY FOR PAYMENT In consideration of services to be rendered at SAH, the undersigned agrees, as patient or guarantor for patient, to pay SAH for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. I accept responsibility for any costs, including attorney's fees, incurred in the collection of these charges. I understand that if I do not consent to the release of information, or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this hospital treatment is, to the best of my knowledge, complete and accurate.

3. ASSIGNMENT OF INSURANCE BENEFITS/FINANCIAL OBLIGATION
Medical care has been or will be provided to me or my dependent by SAH and my physician(s). IN CONSIDERATION OF THE SERVICES RENDERED AT SAH, I: 1) ASSIGN, TRANSFER AND SET OVER TO SAH ALL OF MY RIGHTS, TITLE AND INTEREST TO MEDICAL REIMBURSEMENT UNDER ANY INSURANCE POLICY, INCLUDING BUT NOT LIMITED TO, MEDICARE, MEDICAID, MANAGED CARE OR GROUP ACCIDENT OR HEALTH INSURANCE FOR WHICH BENEFITS MAY BE AVAILABLE FOR PAYMENT OF THE SERVICES RENDERED; and 2) I understand that I am responsible to conform to any requirements of my insurance company or managed health care plan for referral from my primary care physician, authorization, notification, and pre-certification, and 3) that if the medical insurance coverage is not sufficient to satisfy SAH charges in full or if I do not fulfill the requirements of my insurer, I acknowledge that I am fully responsible for the payment of any balance (excluding those charges not collectable pursuant to Medicare regulation) or any reductions in payment made by my insurance because of a failure to meet the requirements of my insurer. If I have any questions about my health insurance coverage or benefits I will contact the insurance company or health insurance plan.

4. AUTHORIZATION FOR RELEASE OF INFORMATION
A. GENERAL RELEASE: I authorize SAH to release and/or provide copies of any and all pertinent information contained in my medical record, including my social security number, billing information, history, all diagnoses, and notes to: 1) My physician(s); 2) My insurance company or utilization review company or any other third party payor, its agents or contractors who are responsible for payment of my bill; 3) Any organization or government agency authorized to license or accredit SAH or to review quality, utilization, or cost of care rendered; 4) Any person or organization involved in discharge planning; 5) Referring and follow-up health care providers after an emergency room or inpatient or outpatient visit; 6) My employer's Workman's Compensation insurer or any agents or contractors for my employer if I have been injured at work or in an accident related to my work.

B. ACCESS TO PRIOR RECORDS. I understand my treating physicians, nurse and other health care providers have access to any of my prior medical records in the custody of SAH as needed to render appropriate care during my stay/visit.

C. SPECIFIC RELEASE FOR MENTAL HEALTH, DRUG OR ALCOHOL ABUSE OR HIV INFORMATION.
1). I specifically authorize SAH where I may be treated for one or more of the following conditions: **mental health, drug or alcohol abuse, or HIV and related diseases** to release any and all information contained in my past or current medical records to the persons and organizations and for the purposes stated in 4A and B. I agree that the specific consent contained in this paragraph shall apply even if I am diagnosed with and/or treated for one of the above conditions after I have signed consent for the current visit/stay.

2) By initialing the condition(s) below, I am indicating that I do not consent to the release of such medical information, if any, to third party payors and understand that I am personally responsible for payment if I do not authorize consent.

Mental Health _____ Drug and Alcohol Abuse _____ HIV _____

3) Duration and Revocation of Consent for Release of Information. This consent to release information under this section C expires one year after the date of signature below. This consent may be revoked at any time by written notice to the Health Information Management Department (with no effect on prior disclosures). With respect to the release of information under sections A and B, this authorization is valid until such time as all available insurance benefits have been received and/or up to 90 days after the date of discharge. I understand that I have the right to revoke this authorization, in writing at any time (except to the extent action(s) have or has been taken in reliance upon it). However, in the event that my revocation prevents payment for the services received, then I will assume responsibility for payment. Questions about Coverage or Benefit Levels Should Be Directed to the Patient's Health Care Plan.

D. MEDICARE BENEFITS. If I am requesting Medicare benefits, I certify to the truth of the information I have provided on the Medicare Secondary Payor ("MSP") form. I request that payment of the authorized benefits under Medicare Part A and Medicare Part B be made to SAH and my physician(s) on my behalf. (a) For Inpatients: If it becomes necessary, do we have your authorization to bill Medicare Life Time Reserve Days? Yes E No E. You have 90 days to withdraw your permission after discharge date. (b) My signature acknowledges my receipt of an Important Message from Medicare and does not waive any of my rights to request review.

E. HEALTH CARE OPERATIONS. I understand that SAH may use and disclose medical information about me for SAH operations in order to run SAH and make sure that all of its patients receive quality care. SAH may use medical information to review treatment and services and to evaluate the performance of its staff in caring for me. SAH may also combine medical information about many patients to decide what additional services SAH should offer and what services are not needed. SAH may also combine the medical information it has with medical information from other hospitals to compare how it is doing and see where it can make improvements in the care and services it offers. SAH may remove information that identifies me from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

5. INDEPENDENT PHYSICIAN SERVICES. I understand that many of the physicians on the staff of this hospital are not employees or agents of the hospital but rather are independent providers who have been granted the privilege of using its facilities for the care and treatment of their patients. They include, but are not limited to, my physician, radiologists, anesthesiologists, pathologists, surgeons, obstetricians and other specialists. My decision to seek care is not based upon any understanding, representation or advertisement that the physicians who will be treating me are employees or agents of SAH. I understand that the physicians who will be providing such professional services will be doing so on my behalf and as such will be my employees or agents. SAH bills do not include physician services and I understand that I will receive a separate physician bill and that these physicians may not be participating providers in the same insurance plans and\or networks as SAH. I am also aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination at SAH. I also authorize SAH to retain, preserve and use for scientific or teaching purposes, or dispose of, at their convenience, any specimens or tissues taken from my body during the course of services rendered.

6. PERSONAL PROPERTY. I assume full responsibility for my personal property and valuables that I may bring to SAH. I understand that upon request, my valuables can be kept in SAH's safe. Otherwise, SAH is not responsible for the loss of any of my personal property.

7. NOTICE OF PRIVACY PRACTICES. My signature acknowledges that I have been offered a copy of SAH's Notice of Privacy Practices at the time of Registration.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONFIRM THAT I AM THE PATIENT OR AM AUTHORIZED TO SIGN ON THE PATIENT'S BEHALF.

CPD

(Signature of Patient or Representative

Relationship to patient (if applicable)

Mayrah

Signature of Witness

04-17-2014

Date

Reason why Pt. did not sign

Date

Saint Anthony Hospital
EMERGENCY FLOW SHEET RECORD
Name: Townsend, Tijuan Age: 35Y MR: 2796347 Acct: 200509539

VITAL SIGNS	JT
TIME	4/17/2014 09:30
BP	161/115
PULSE	100
RESP	20
TEMP	98.8
PAIN	10
O2 SAT	95 on Room Air

SSSSS

SAINT ANTHONY HOSPITAL
PRIMARY

Townsend, Tijuan
DOB: 9/14/1978 M35
Wt/Ht: 86.2 Kg
MedRec: 2796347
AcctNum: 200509539

Patient Data

Complaint: Cpd Custody Battery Pcp Unknown
Triage Time: Thu Apr 17, 2014 09:35
Urgency: 3–Urgent
Bed: ED HOLDING
Initial Vital Signs: 4/17/2014 09:30
BP:161/115
P:100
O2 sat:95 on Room Air

ED Attending: Grimes, MD, Ephriam
Primary RN: Hernandez, RN, Juan

R:20
T:98.8
Pain:10

DISPOSITION

PATIENT: Disposition Type: Discharged, Disposition: D/C WITH LAW ENFORCEMENT, Condition: Stable. (11:06 ETG)
Patient left the department. (11:51 MGC)

TRIAGE (10:09 JT)

TRIAGE NOTES: **to cart 6 per by cfd #44 under cpd custody (bt 6223E, str 4634) pt aox3 states was beaten to face and kicked in groin, no loc, dry blood noted face,color good, skin warm dry to touch , denies swallowiing drugs but had snorted heroin and smoked cocaine this am.** (10:09 JT)
ADMISSION: URGENCY: 3–Urgent, ADMISSION SOURCE: OTHER, TRANSPORT: CHICAGO FIRE DEPT., BED: ED 06. (Thu Apr 17, 2014 09:35 JT)
VITAL SIGNS: BP 161/115, Pulse 100, Resp 20, Temp 98.8, Pain 10, O2 Sat 95, on Room Air, Time 4/17/2014 09:30. (Thu Apr 17, 2014 09:35 JT)
COMPLAINT: (cpd custody) battery. (Thu Apr 17, 2014 09:35 JT)
ASSESSMENT: Triage assessment performed. (Thu Apr 17, 2014 09:35 JT)
IMMUNIZATIONS: Unknown when last tetanus shot recived. (Thu Apr 17, 2014 09:35 JT)
TREATMENTS IN PROGRESS: No treatment. (Thu Apr 17, 2014 09:35 JT)
TREATMENTS IN TRIAGE: Triage assessment performed, No treatment administered in triage. (Thu Apr 17, 2014 09:35 JT)
ES LEVEL: ES level 2. (Thu Apr 17, 2014 09:35 JT)
PROVIDERS: TRIAGE NURSE: Jeannine Tchernow, RN. (Thu Apr 17, 2014 09:35 JT)
PATIENT: NAME: Townsend, Tijuan, GENDER: male, LANGUAGE: ENGLISH, Mode of Arrival: Ambulance, Accompanied By: Chicago Police, Adult/Child Abuse: NA, KG WEIGHT: 86.2, Attending: none. (Thu Apr 17, 2014 09:35 JT)
AGE: 35, DOB: Thu Sep 14, 1978. (10:01 MH1)

DIAGNOSIS (11:06 ETG)

FINAL: PRIMARY: **Facial laceration**, ADDITIONAL: **intraoral laceration**.

ALLERGY (09:35 JT)

No Known Drug Allergies (NKDA)

KNOWN ALLERGIES

No Known Drug Allergies (NKDA)

O2SAT INTERPRETATION (11:04 ETG)

O2SAT: O2 saturation reading 95%, O2 AMT: R.A., O2 Sat normal, None needed.

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Townsend, Tijuan
DOB: 9/14/1978 M35
Wt/Ht: 86.2 Kg
MedRec: 2796347
AcctNum: 200509539

ATTENDING (11:05 ETG)
NOTES: I have personally seen and examined this patient. I have fully participated in the care of this patient. I have reviewed all pertinent clinical information, including history, physical exam and plan.

PRESCRIPTION
No recorded prescriptions

HPI BLANK (11:01 ETG)
CHIEF COMPLAINT: **35 y/o male arrives in CPD custody stating that he was assaulted by police officer. Patient states that he argued with the officer then the officer kicked him. Patient then states that when he turned to defend himself, he got hit in the face. Patient complains of abrasions to face and cut to inner lip. Patient denies LOC.** *HISTORIAN:* History obtained from patient. *TIME COURSE:* **Patient currently has symptoms.** *SEVERITY:* Maximum severity is **mild,** Currently **symptoms are mild.**

NURSING PROCEDURE: DISCHARGE NOTE (11:46 JH)
TIME: discharged to. police custody, Patient, ambulates with assistance, Transported via police, Accompanied by guard, Discharge instructions given to, patient, Simple/moderate discharge teaching performed, Above Person(s) verbalized understanding of discharge instructions and follow-up care, **Patient discharged at 1144.**

NURSING PROCEDURE: WOUND CARE (10:20 JH)
TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Procedure was performed at 1015, Wound site: mouth, Cause of wound trauma, Wound irrigated with, 500ml, Wound cleansed in, NS.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.

CURRENT MEDICATIONS (09:36 JT)
norvasc not taking x 3 mos
hiv meds not taking x 3 mos

ROS (11:01 ETG)
SKIN: **Historian reports skin lesions.**
NOTES: All systems were reviewed and are negative except as described above.

PAST MEDICAL HISTORY
MEDICAL HISTORY: **History of human immunodeficiency virus, Patient is noncompliant with treatment, History of hypertension, Patient is noncompliant with treatment.** (Thu Apr 17, 2014 09:35 JT)
SURGICAL HISTORY: Patient has had no previous surgical history. (Thu Apr 17, 2014 09:35 JT)
PSYCHIATRIC HISTORY: No previous psychiatric history. (Thu Apr 17, 2014 09:35 JT)
SOCIAL HISTORY: Lives with others, **Patient smokes tobacco, consumes alcohol socially. snorted heroin and smokes cocaine this am.** (Thu Apr 17, 2014 09:35 JT)

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SAINT ANTHONY HOSPITAL
PRIMARY

Townsend, Tijuan
DOB: 9/14/1978 M35
Wt/Ht: 86.2 Kg
MedRec: 2796347
AcctNum: 200509539

FAMILY HISTORY: Family history is not contributory to this case. (Thu Apr 17, 2014 09:35 JT)
NOTES: Nursing records reviewed, Agree with nursing records. (10:53 ETG)

PHYSICAL EXAM (11:03 ETG)
CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed, Patient has normal pulse, normal blood pressure, normal respiratory rate. Well appearing, Patient appears comfortable, Alert and oriented X 3.
HEAD: Normocephalic, **abrasion .2cm laceration L upper lip.**
EYES: Eyes are normal to inspection, Pupils equal, round and reactive to light, No discharge from eyes, Extraocular muscles intact, Sclera are normal, Conjunctiva are normal.
ENT: Ears normal to inspection, Nose examination normal, Posterior pharynx normal, **.7cm laceration L. inner angle of the lip. Does not extend to the outside.**
NECK: Normal ROM, No jugular venous distention, meningeal signs. Cervical spine nontender.
RESPIRATORY CHEST: Chest is nontender, Breath sounds normal, No respiratory distress.
CARDIOVASCULAR: RRR, No murmurs, Normal S1 S2, No rub, gallop.
ABDOMEN: Abdomen is nontender, No masses, Bowel sounds normal, No distension, peritoneal signs.
BACK: There is no CVA Tenderness, There is no tenderness to palpation, Normal inspection.
UPPER EXTREMITY: Inspection normal, No cyanosis, clubbing, edema. Normal range of motion, pulses. .
LOWER EXTREMITY: Inspection normal, No cyanosis, clubbing, edema. Normal range of motion, No calf tenderness, Normal pulses.
NEURO: GCS is 15, No focal motor deficits, focal sensory deficits, cerebellar deficits. Speech normal, Gait normal, Memory normal.
SKIN: Skin is warm, Skin is dry, Skin is normal color.
PSYCHIATRIC: Oriented X 3, Normal affect, insight, concentration.

DOCTOR NOTES (11:05 ETG)
TEXT: **35 y/o male battery with facial lacerations. Stable. None requiring sutures. D/C to police custody. tetanus UTD. Evidence officer presented to ED to take pictures of patient's wounds.**
PATIENT STATUS: Patient has stabilized since arrival to emergency department.
PATIENT PLAN: The patient will be discharged.

EVENTS
ATTENDING: Grimes, MD, Ephriam saw patient at Thu Apr 17, 2014 09:53. (09:53 ETG)
TRANSFER: Triage to Emergency ED MAIN ROOM 06. (Thu Apr 17, 2014 09:35 JT)
Emergency ED MAIN ROOM 06 to HOLDING. (11:47 JJH)
Removed from Emergency HOLDING. (11:51 MGC)

NURSING ASSESSMENT: FALL RISK (09:39 JJH)
FALL RISK: Total score is: pain, Risk for fall (score of 5 or greater).

NURSING ASSESSMENT: FOCUSED (10:08 JJH)

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SAINT ANTHONY HOSPITAL
PRIMARY

Townsend, Tijuan
DOB: 9/14/1978 M35
Wt/Ht: 86.2 Kg
MedRec: 2796347
AcctNum: 200509539

NURSING DIAGNOSIS: **laceration to inside mouth.**
CONSTITUTIONAL: History obtained from patient, Patient is cooperative, alert and oriented x 3. Patient arrives to treatment area **via EMS.**
NOTES: **cpd custody patient c/o pain to inside of mouth. laceration noted. dry blood to face. deneis loc.**
SAFETY: Side rails up, Cart in lowest position.

VITAL SIGNS (Thu Apr 17, 2014 09:35 JT)
VITAL SIGNS: BP: 161/115, Pulse: 100, Resp: 20, Temp: 98.8, Pain: 10, O2 sat: 95 on Room Air, Time: 4/17/2014 09:30.

INSTRUCTION (11:10 ETG)
DISCHARGE: FACIAL LACERATION, LACERATION CARE, ADULT.
FOLLOWUP: Fantus Health Center, Clinics of Cook Co, Family Practice, 621 S. Winchester, Chicago IL , 312–864–8682, Call for appointment.
SPECIAL: Follow up with your private MD in the AM. Return to ED if worse.

ADMIN
DIGITAL SIGNATURE: Grimes, MD, Ephriam. (15:14 ETG)
Tchernow, RN, Jeannine. (Sat Apr 19, 2014 10:48 JT)

Key:
ETG=Grimes, MD, Ephriam IJH=Hernandez, RN, Juan JT=Tchernow, RN, Jeannine MGC=Cardenas, COOR., Maria MH1=Hernandez, Mayra

$$$$$

2ER

SAINT ANTHONY HOSPITAL

St. Anthony Hospital
E.D. Medical Record

Acuity	E.R. Location
1 2 3	| |

DATE: TRIAGE TIME: TIME TO ED:

Police Beat: STAR:	Ambulance	Family Notified ☐ Yes ☐ No	Police Notified ☐ Yes ☐ No

Patient Name (First, Last, Mi.) | Age | Sex ☐ M ☐ F

H.M.O. ☐ Denied ☐ Approved By:

Mode of Arrival ☐ Walked ☐ W/C ☐ Ambulance

200509539 2796347 09/14/1978
TOWNSEND TIJUAN
04/17/2014 09:59 UNKNOWN_ROOM Male 35Y
GRIMES EPHRIAM

Patient's Physician:

T	P	R	BP	LMP

COMMUNICATION BARRIERS

Hearing Impaired ☐ Yes
Visually Impaired ☐ Yes
If English is not the primary language, language spoken: _____
Interpreter called ☐ Yes ☐ No
Other _____ Initials _____

If the patient is injured, does the patient state that He/She is a victim of domestic violence? ☐ Yes ☐ No

WT. | G

LOC. ☐ Yes ☐ No | P

☐ Tetanus | ☐ Pediatric Immunization | A

Triage Nurse Signature

Chief Complaint

PMHX:

Medications:

Allergies:

☐ X-Ray _____ ☐ EKG _____ ☐ ER ☐ Radiologist

TREATMENT/ORDERS

Time		Time	Initials

Diagnosis

E.D. Physician-Print/Signature

Notified Patient's Physician ☐ Yes ☐ No ☐ No Answer
Physician Notified

Disposition: ☐ Admit ☐ ICU/CCU ☐ Telemetry ☐ Med/Surg. ☐ OB/GYN ☐ Peds.
☐ Psych. ☐ LWOT ☐ AMA ☐ Home _____
☐ Observation Room # _____ ☐ Transfer _____

Referred To: _____ Date to be seen: _____

Condition on Discharge: ☐ Good ☐ Fair ☐ Serious ☐ Critical ☐ Expired

Time	Orders
	☐ CBC
	☐ SMA-7B
	☐ SMA 20
	☐ PT/PTT /
	☐ UA
	☐ DIPSTICK
	☐ UCG
	☐ CULTURE/SENSITIVITY
	☐ URINE
	☐ BLOOD
	☐ OTHER
	☐ AMYLASE
	☐ ETOH
	☐ UDS ☐ MB
	☐ CPK
	☐ ABG
	☐ SaO2
	☐ EKG
	☐
	☐
	☐
	RADIOLOGY ORDERS
	☐ CHEST-PORT
	☐ CHEST-PA/LAT
	☐ C-SPINE LAT.
	☐ C-SPINE SERIES
	☐ ANKLE R L
	☐ FOOT R L
	☐ WRIST R L
	☐ HAND R L
	☐ FINGER
	☐ PELVIS
	☐ HIP R L
	☐ CT
	☐
	☐ PAST MEDICAL RECORDS
	☐

784447283 (07/10)

MEDICAL RECORDS

$$$$$

CONSENT FOR DIAGNOSIS AND TREATMENT AND RELEASE OF INFORMATION

NOTE: FOR SURGERY TO BE PERFORMED IN ONE OF THE HOSPITAL OPERATING ROOMS, THE "CONSENT FOR SURGERY OPERATION" FORM IS TO BE SIGNED IN ADDITION TO THE FOLLOWING CONSENT.

1. I, THE PATIENT NAMED ON REVERSE SIDE, AM VISITING ST ANTHONY HOSPITAL EMERGENCY DEPT AS AN OUTPATIENT FOR THE PURPOSE OF DIAGNOSIS AND MEDICAL OR SURGERY TREATMENT AND DO HEREBY CONSENT AND AGREE TO SUBMIT TO SUCH DIAGNOSTIC PROCEDURE AND TO SUCH MEDICAL, SURGICAL, OR X-RAY NUCLEAR ELECTRICAL, AND LABORATORY TESTS OR TREATMENT BY MY PHYSICIANS, HIS ASSISTANTS OR HIS DESIGNEES AS IS NECESSARY IN HIS JUDGEMENT.
2. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENTS OR EXAMINATION IN THE HOSPITAL.
3. FURTHER, I HEREBY AUTHORIZE SAID CATHOLIC HEALTH PARTNERS HOSPITAL AND PHYSICIAN TO RELEASE ANY INFORMATION REGARDING THIS TREATMENT OR SUBSEQUENT TREATMENT RELATIVE TO THIS INJURY OR ILLNESS FOR THE PURPOSE OF COMPLETING INSURANCE FORMS WHICH I MAY SUBMIT OR WHICH MAY BE SUBMITTED BY OTHERS IN CONNECTION WITH THIS CASE.
4. I CERTIFY THAT THIS FACILITY IN COMPLIANCE WITH THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 AND ITS AMENDMENTS, HAS OFFERED TO PROVIDE ME A MEDICAL SCREENING EXAM WITHOUT REGARD TO MY ABILITY TO PAY.
5. THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

CONSENTIMIENTO PARA DIAGNOSIS TRATAMIENTO Y CESION DE INFORMACION

AVISO: ANTES DE QUE SE EJECUTE SIRUGÍA EN UNO DE LOS SALONES DE OPERACÍON DE ESTE HOSPITAL, TIENE QUE FIRMAR EL FORMULARIO DE "CONSENTIMIENTO DE OPERACION QUIRURGICA" AL IGUAL QUE ESTE FORMULARIO DE CONSENTIMIENTO.

1. YO, EL PACIENTE NOMBRADO EN EL LADO OPUESTO, ESTOY VISITANDO EL SALÔN DE EMERGENCIA DEL HOSPITAL COMO PACIENTE PARA EL PROPÔSITO DE DIAGNOSIS Y TRATAMIENTO MEDICO O DE SIRUGÍA. POR ESTE MEDIO CONSIENTO Y ESTOY DE ACUERDO CON SOMETERME A LOS PROCEDIMENTOS DIAGNÓSTICOS Y A LOS EXÁMANES O TRATAMIENTOS MÉDICOS, QUIRÚRGICOS, NUCLEARES, ELECTRICOS, DE LABORATORIO, DE RAYOS X, DE SANGRE QUE SEAN NECESARIAS DE ACUERDO A LA DECISIÓN DE MIS DOCTORES, SUS ASISTENTES O SUS DESIGNADOS.
2. SÉ QUE LA PRÁCTICA DE MEDICINA SIRUGÍA NO ES UNA CIENCIA EXACTA Y RECONOZCO QUE NO ME HAN DADO GARANTÍAS EN QUANTO AL RESULTADO DE LOS TRATAMENTOS O EXÁMENES EN EL HOSPITAL.
3. ADEMÁS, POR ESTE MEDIO AUTORIZO AL HOSPITAL CATHOLIC HEALTH PARTNERS DOCTORES A CEDER CUALQUIER INFORMACIÓN RESPECTO A ESTE TRATAMIENTO O TRATAMIENTO SUBSIGUIENTE RELATIVO A ESTA HERIDA O ENFERMEDAD PARA EL PROPÓSITO DE COMPLETAR FORMULARIOS DE SEGURO LOS CUALES YO PUEDO SOMETER O LOS CUALES PUEDEN SOMETER OTROS EN CONEXIÓN CON ESTE CASO.
4. YO AFIRMO QUE EL DOCTOR ME A OFRECIDO UN EXAMEN MEDICO, SIN TOMAR EN CUENTA MI ABILIDAD DE PODER PAGAR POR EL SERVICO. EN COMPLIMIENTO CON LA CONSILIDAD DEL ACTO DE OMNIBUS BUDGET RECONCILIACION DE 1985 Y SUS AMENDOMINITOS.
5. ESTE FORMULARIO SE ME HA EXPLICADO ENTERAMENTE Y AFIRMO QUE ENTIENDO SUS CONTENIDOS.

SIGNED/FIRMA _____
Patient Name/Nombre del Paciente — Date/Fecha

WITNESS/TESTIGO _____
Date/Fecha

RELEASE FROM RESPONSIBILITY OF DISCHARGE

Date _____ Time _____

This is to certify that I, _____

a patient in St. Anthony Hospital, am leaving the hospital against the advice of the attending physician and of the hospital administration. I acknowledge that I have been informed of the risk involved and hereby release the attending physician, the hospital and its employees from all responsibility for any ill effects which may result from this action.

Witness _____ **Signed** _____
(PATIENT OR NEAREST RELATIVE)

Witness _____ **Relationship** _____

RELEVO DE RESPONSIBILIDAD AL SER DADO DE ALTA

Fecha _____ Hora _____

Esto certifica que yo, _____

une paciente en el Hospital St. Anthony he decidio retirarme de dicho hospital contra el deseo y la recomondacion del medico y, direccion Administrativa. He sido informado sobre los reisgos al actuar como tal y de esta manera libero al medico, el hospital y sus empleados, de cualquier consequencia al yo tomar esta decision.

Testigo _____ **Firma** _____
(paciente o miembro de la familia)

Testigo _____ **Relacion** _____

SSSSS

SAINT ANTHONY HOSPITAL
Patient Profile report

Patient Name: **TOWNSEND, TIJUAN**

Visit ID: **200509539** MR Number: **2796347** DOB: **09/14/1978**

Admit: **04/17/2014** Location: **UNKNOWN_LOCATION UNKNOWN_ROOM UNKNOWN_BED**

Demographics

Called Name:

Sex: Male

Primary Address

1225 S AUSTIN BOULEVARD
CHICAGO, IL 60804
Country: UNITED STATES

Phone Numbers

Home Telephone Number: (111)111-1111
Home Telephone Number: (708)863-3840
Home Telephone Number: (773)678-8372

Contacts

Name	Type	Next of Kin	Emergency Contact	Guardian	Agent	Phone	Phone Type
TOWNSEND, MERYLIN	OTHER RELATIONSHIP	Y	N	N	N	(708)863-3840	Home Telephone Number

Highest Education Level:

***NO SCHOOL DATA ***

***NO OCCUPATIONAL HISTORY DATA ***

Patient Education

*** NO PATIENT EDUCATION DATA ***

SSSSS

SAINT ANTHONY HOSPITAL
Patient Profile report

Patient Name: **TOWNSEND, TIJUAN**

Visit ID: **200509539** MR Number: **2796347** DOB: **09/14/1978**

Admit: **04/17/2014** Location: **UNKNOWN_LOCATION UNKNOWN_ROOM UNKNOWN_BED**

Patient Detail

Admit Complaint: Facial laceration intraoral laceration

Admit Diagnosis:

Service: EMERGENCY Fin Class: SELF PAY Patient Type: EMERGENCY

Discharge Date: 04/17/2014 Discharge Status: DC/XFER TO COURT/LAW ENFORCE Visit Status: Discharge

Race: BLACK OR AFRICAN AMERICAN Age: 35 YEARS BSA:

Admit Weight: Admit Height:

Current Weight: Current Height: BMI:

Notes:

Smoking Status: Never smoker (266919005) Code Status:

***NO ISOLATION CODES DATA ***

Language: English

Language Ability Mode Expressed:

Language Ability Mode Received:

Communication Barrier:

Special Needs:

Organ Donor: N Last Menstrual Period: Lactating:

Pregnant: Exp. Delivery (Date): Gest. Age at Birth (Date):

Exp. Delivery (US): Gest. Age at Birth (US):

Advance Directives

Document Name	Doc In Chart	Effective Date/Time	Type	Custodian Name, Address and Phone Number
UNKNOWN	N	03/24/2004 18:43		
Note:				
NONE	N	02/12/2014 13:19		
Note:				

Physicians

Admitting - EPHRIAM GRIMES MD

Attending - EPHRIAM GRIMES MD

Referring - EPHRIAM GRIMES MD

Allergies

Current Allergy	Severity	Onset Date	Reaction	Type	Sensitivity

Note:

Pre-arrival Medications

*** NO PRE-ARRIVAL MEDICATION DATA ***

Home Medications

Drug Description and Form	Dose	Route	Frequency	PRN	Duration	Start Date	Stop Date	Last Date Taken

SSSSS

SAINT ANTHONY HOSPITAL
Patient Profile report

Patient Name: TOWNSEND, TIJUAN

Visit ID: 200509539 MR Number: 2796347 DOB: 09/14/1978

Admit: 04/17/2014 Location: UNKNOWN_LOCATION UNKNOWN_ROOM UNKNOWN_BED

Immunizations

Immunization | Dose / Units | Route | Site | Admin Date Time | Lot # | Exp Date | Manufacturer

Immunization Condition

None Given Reason:
Comments:
Administered By:

Consent Status | Consent Date Time | Consent Relationship | Consent Name

VIS Given Date Time | VIS Version

Problem List - Current Visit

Entry Date | Status | Type | Code | Description

Problem List - Full

Entry Date | Status | Type | Code | Description

Implants

Date | Description | Size | Quantity | Site | Model # | Serial # | Lot #

Patient Reported Problems

Description | Type | Status | Treating Provider

Patient Reported Procedures

Description | Treating Provider

Laterality | Severity | Start Date | Start Time | End Date | End Time

Unknown

Tobacco Use

Tobacco Type | Amount | Frequency | Duration | Start | Quit | Pack years | Total Pack years

Alcohol Use

Alcohol Type | Amount | Frequency | Duration | Quit

Recreational Drug Use

Start Date | Classification | Drug Name | Alt Name | Amount | Frequency | Duration | Quit

SSSSS

SAINT ANTHONY HOSPITAL
Patient Profile report

Patient Name: TOWNSEND, TIJUAN

Visit ID: 200509539 MR Number: 2796347 DOB: 09/14/1978

Admit: 04/17/2014 Location: UNKNOWN_LOCATION UNKNOWN_ROOM UNKNOWN_BED

Family History

Adopted: N

Relationship	Name	Age	DOB	Race	Ethnicity	Alive / Deceased	Cause of Death

Note:

Patient Detail Documentation

BMI:

Calculated field

BSA:

Calculated field

UNKNOWN:

NONE:

SSSSS

Name: Townsend, Tijuan
Age: 35Y DOB: Sep 14, 1978
Gender: M Wt: 86.2 kg
MedRec: 2796347
AcctNum: 200509539
Attending: ETG
Primary RN: JJH
Bed: ED ED 06

SAINT ANTHONY HOSPITAL
DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
Facial laceration

ADDITIONAL DIAGNOSIS
intraoral laceration

FOLLOWUP CONTACT

Fantus Health Center, Clinics of Cook Co, Family Practice
621 S. Winchester
Chicago IL
Phone: 312-864-8682
Comment: Call for appointment

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
Follow up with your private MD in the AM. Return to ED if worse.

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
FACIAL LACERATION
LACERATION CARE, ADULT

I have received and understand my discharge instructions and follow up care.

He recibido y entendido mis instrucciones para el alta y la atención de seguimiento.

X_____

Staff Giving Discharge instructions:

X_____

$$$$$